Massachusetts Department of Public Health

PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, May 23, 2000, 10:00 A.M., Massachusetts Department of Public Health, 250 Washington Street, Floor 2, Boston, Massachusetts. Present were: Dr. Howard K. Koh (Chairman), Dr. Clifford Askinazi, Mr. Manthala George Jr., Ms.Shane Kearney Masaschi, Mr. Benjamin Rubin, Mr. Albert Sherman, Ms. Janet Slemenda, and Dr. Thomas Sterne. Also in attendance was Ms. Donna Levin, General Counsel.

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Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A 1/2.

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The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Mr. Robert Goldstein, Division of Epidemiology and Immunization; Dr. Bela Matyas, Bureau of Communicable Disease Control; Ms. Nancy Ridley, Assistant Commissioner, Bureau of Health Quality Management; Dr. Grant Carrow, Director, Division of Drug Control; Ms. Sally Cheney, Bureau of Immunization Control; Ms. Adele Audet, Assistant Director, Drug Control Program; Dr. Gregory Connolly, Director, Massachusetts Tobacco Control Program; Dr. Paul Dreyer, Director, Division of Health Care Quality; Ms. Joyce James, Director, Mr. Jere Page, Senior Program Analyst, Ms. Joan Gorga, Program Analyst, Determination of Need Program; and Attorneys Howard Saxner and Carl Rosenfield, Deputy General Counsels, Office of the General Counsel.

PERSONNEL ACTIONS:

In a memorandum, dated April 28, 2000, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Victoria Johnson to Program Manager VI (Director, Client Services). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6 the appointment of Victoria Johnson be approved.

In a memorandum, dated May 10, 2000, Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Donna Shecrallah to Program

Manager V (MassCARE Director). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6 the appointment of Donna Shecrallah be approved.

In a letter dated May 4, 2000, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of the appointments and reappointments to the provisional, consultant, and affiliate medical staffs of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the provisional, consultant, and affiliate medical staffs of Tewksbury Hospital be approved for a period of two years beginning May 1, 2000 to May 1, 2002:

APPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Kevin Mack, M.D.	Provisional Affiliate/Psychiatry	150257
Peter Brigham, M.D.	Provisional Affiliate/Psychiatry	49672
Naaznin Lokhandwala, M.D.	Provisional Affiliate/Internal Medicine	157742

REAPPOINTMENTS	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Neil Kowall, M.D.	Consultant Neurology	46511
Carmencita Lopez, M.D.	Consultant Neurology	76374
Boris Vatel, M.D.	Affiliate Psychiatry	152685

In a letter dated May 9, 2000, Blake Molleur, Executive Director, Western Massachusetts Hospital, recommended approval of the reappointment of a dentist to the consulting medical staff of Western Massachusetts Hospital, Westfield. Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointment to the consulting medical staff of Western Massachusetts Hospital be approved:

REAPPOINTMENT	**RESPONSIBILITY**	**MEDICAL LICENSE NO.**

Leslie Zide, DMD	Dentist	14059

In a letter dated May 8, 2000, Robert D. Wakefield, Jr., Executive Director, Lemuel Shattuck Hospital, recommended approval of the appointment and reappointment of physicians to the medical staff of Lemuel Shattuck Hospital, Jamaica Plain. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees'qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointment and reappointment to the medical staff of Lemuel Shattuck Hospital be approved:

APPOINTMENT	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Carol Garner, M.D.	Active/Internal Medicine	54221
REAPPOINTMENT	**STATUS/SPECIALTY**	**MEDICAL LICENSE NO.**
Bradford Navia, M.D.	Active/Neurology	56112

STAFF PRESENTATION:

"MASSACHUSETTS HEPATITIS C INITIATIVE" by Bela Matyas, M.D., Barbara Werner, Ph.D.,and Robert Goldstein, M.P.H.

Mr. Robert Goldstein, M.P.H., Division of Epidemiology and Immunization, Bureau of Communicable Disease, said, "Hepatitis C represents a significant public health problem. There are an estimated four million Americans who are affected by Hepatitis C, and there has been a very rapid increase in diagnosed cases throughout the country. Hepatitis C represents a hidden epidemic because most of the individuals who are affected by Hepatitis C are unaware that they have the disease. Most individuals who contract Hepatitis C do not have symptoms but they do go on to have chronic development of progressive liver disease. About 85% of those infected become chronic carriers, and they develop some degree of liver disease, from mild to very serious. It is important to remember that Hepatitis C is a different virus from Hepatitis A and Hepatitis B. It causes liver disease, as do A and B, but it's a different virus, it transmits differently, and it has different implications. Hepatitis C can result in liver damage, including liver cirrhosis and liver cancer. In Massachusetts, we estimate that 100,000 residents are affected by Hepatitis C, and if these people are not medically managed, as many of 20,000 will go on to develop serious liver disease as a result. Anywhere from 1,000 to 5,000 of these individuals may well go on to die of liver disease from such liver disease complications as severe cirrhosis or liver cancer. Many of them will also require liver transplants. Unlike Hepatitis A and Hepatitis B, this particular disease does not have a vaccine and there are only limited treatments that are available to help those patients who have Hepatitis C. So

that it is very critical that we focus on early detection for those individuals who have the disease, and on prevention, so that others do not get the disease. Hepatitis C is transmitted primarily through blood and bodily fluids. This is the most important way in which it is transmitted and in this way, it is similar to Hepatitis B. It can also be transmitted sexually, although this is a much less efficient way for it to be transmitted than blood transmission. In addition, it can also be transmitted from mother to unborn child, perinatal transmission, but it is important to remember that Hepatitis C is not spread casually."

Mr. Goldstein continued with the risk factors for transmission, "Most people who have Hepatitis C have contracted it as a result of blood transfusions or organ transplants that they received prior to the time when the blood supply was screened for this virus. So prior to June of 1992, there was a meaningful risk of exposure to Hepatitis C if you were receiving a blood transfusion. Most of the remaining population who have contracted the disease have gotten it because of IV drug use. And because this virus transmits so easily through the blood, a single episode of IV drug use is sufficient to transmit disease. So many of the people who may have engaged in activities once or twice when they were younger and may not recall those activities, and certainly don't consider themselves to be IV drug users, are in fact, at risk because of that type of transmission. Individuals who receive hemodialysis are at risk, and their risk increases with the number of years on hemodialysis. It can also be transmitted from infected mothers to their unborn children. It can potentially be transmitted through other recreational drug use, such as cocaine with sharing of straws. Blood can be transmitted on the nasal straws. Sex with an infected partner is another means by which the disease can be transmitted, and the risk of sexual transmission increases in those individuals who have another sexually transmitted disease, or who have multiple sex partners. Health care workers can contract the disease through occupational exposures involving accidental needle injuries. Individuals who are positive can pass the disease to household members through sharing of personal items, such as razors. And it is possible that the disease can be spread through tattooing and body piercing."

Mr. Goldstein spoke about the significant role of the Hepatitis C Advisory Committee, which through quarterly meetings helps the Department to do a better job with regard to surveillance and epidemiology of the disease; development of education and awareness programs for the public and health care providers; and identification and screening for the disease in special populations such as prisons and substance abuse treatment centers. The Department together with the Advisory Committee developed a needs assessment for health care providers about what they need to learn with regard to Hepatitis C; developed and distributed materials; designed an awareness poster; developed new case report forms for Hepatitis A, B, and C, designates priority populations and serosurveillance projects in prison settings, in substance abuse treatment sites and other settings.

Dr. Bela Matyas, Division of Epidemiology and Immunization, Bureau of Communicable Disease Control, explained the division's new initiatives. They included an RFR process for client services, research, education and training; the development of Interdepartmental Service Agreements with the Department of Corrections and the Department of Mental

Health; a comprehensive media campaign, which included radio spots in English and Spanish, TV time, brochures and posters in English, Spanish and Portuguese; and lastly to have an evaluation contract.

Chairman Koh added, “This is a key public health issue for the new century. There is interest at the federal level and now at the state level to educate the public to make sure people are aware that they may be at risk, to enhance awareness through media, to enhance research, to involve the communities. And there’s an overlap in multiple areas of health, you’ve just heard, with substance abuse issues, with HIV and AIDS issues, with sexually transmitted disease issues. This is a new statewide initiative that we are very proud to have launched and want to see continued and sustained.”

Mr. Goldstein reminded people that the most important thing to do is to ask oneself whether or not you fit into one of the high risk groups, whether you’ve engaged in any of these high risk activities, and that requires a lot of internal honesty: If you have had a blood transfusion or organ transplant prior to June of 1992, adolescent drug use, occupational exposure, sexual history -- whether or not you have had multiple partners who you don’t know the status of with regard to Hepatitis C. If you fall into these types of risk groups, we recommend that you be tested.

Mr.Goldstein further said, “The disease is silent in most people. You’re not going to know that you have the disease until much too late. By the time you develop symptoms, your liver is seriously impaired. The key is to be tested while you are still healthy so that you can begin medical management and hopefully avoid having the serious development of disease.”

In response to a question of what is the difference between Hepatitis C, A, and B by Council Member George, Mr. Goldstein replied, “Hepatitis A is a food borne disease. It’s transmitted from person to person either through bad hygiene where there’s feces remaining on the hand and then you pass it on to another person, or through food or through water. And it causes a diarrheal disease. It’s a short-term acute disease and most people recover without any difficulty. Hepatitis B is a much more dangerous virus. It is a disease that is very easily transmitted through blood and through sex. About 5% of adults who are infected develop chronic disease and can go on to develop liver cirrhosis and cancer. But most people who develop Hepatitis B have an acute disease and then recover from it. However, many people can die of acute Hepatitis B. Hepatitis C is a virus that is much more silent than Hepatitis B. Like Hepatitis B, it’s transmitted primarily through blood and it can be transmitted through sex, but it’s less efficiently transmitted than B. There are fewer people who are exposed to Hepatitis C who actually become infected, but the difference is that most people who get Hepatitis C develop chronic infection. Unlike Hepatitis B where you have the acute disease and then you can recover, you rarely recover from Hepatitis C. With C you develop the disease over 20 to 30 years and develop liver cirrhosis, or liver cancer and then die.”

Professor Hyde, an Advisory Committee member, addressed the Council. His two major points were (1) that primary care physicians need to be educated about the differences in risk factors between B and C and (2) that there will be a lot of people who will begin to develop symptoms in the next five, ten, fifteen years as a result of blood transfusions (i.e., infected before testing of the blood supply began) and will require intensive care and services. Professor Hyde said, "This is not a train wreck waiting to happen but a public health problem – an epidemic."

Council Member Dr. Sterne noted, "There have been at least several studies in the last year that suggested that our pessimism about the fraction of people who go on to become sick will be hopefully lower than our original largest worries. There is some hope, at least, that the number of people infected will not automatically in the future equal the number of people sick."

Chairman Koh added, "Your point is a good one Dr. Sterne. It underscores a message that this is still a relatively new disease for our society. We don't know very much about it, as Professor Hyde and others have pointed out. We need to start with basic awareness in the general population as well as the provider community. Our media outreach efforts here are going to be well received, I'm sure. We are looking to try to identify high risk populations and ultimately protect public health with regard to this issue…"

NO VOTE/INFORMATION ONLY

INFORMATIONAL BRIEFING ON PROPOSED REGULATIONS (105 CMR 700.000) TO ESTABLISH STANDARDS FOR PHARMACIST ADMINISTRATION OF INFLUENZA VACCINE:

Staff said, "The proposed amendment will establish standards for pharmacist dispensing of certain medications by administration. The regulation will enable the Department to implement a pilot project, which is being developed jointly with the Board of Registration in Pharmacy and the Massachusetts Pharmacists Association, on administration by registered pharmacists of influenza vaccine to adults. The training of pharmacists in immunization will also contribute to the state's capacity to respond to a future pandemic."

Dr. Grant Carrow, Director, Drug Control Program, noted that "Together, influenza and pneumonia rank sixth as a cause of death in the general population and fifth among the elderly. According to the DPH behavioral risk factor surveillance system, only about 66% of the target population, that is those 65 years and older in the Commonwealth, were immunized last year. Recently, there have been new recommendations by the Center for Disease Control (CDC) and the Prevention Advisory Committee on Immunization Practices which changes the target population for influenza vaccine, and Sally Cheney is here to explain a little bit about those changes and recommendations."

Ms. Sally Cheney, Bureu of Immunization Disease Control, addressed the Council next. She said in part, "…We have had for a number of years a very proactive and aggressive

influenza effort out of our Bureau of Communicable Disease Control. Last year we distributed about 6,050 doses of flu vaccine. We were only able to successfully reach about two-thirds of the elderly in Massachusetts with immunization vaccinations. This year we are able to purchase more vaccine. We are going to purchase and distribute about just under 750,000 doses. It is still not a sufficient numbers of doses to reach all of the elderly. The CDC's Advisory Committee on Immunization Practices has just lowered the recommended age for immunization to 50 years of age. Therefore, everyone 50 years and older will be targeted for immunization this year." Ms. Cheney noted that in order to reach so many people and prepare for the eventual flu pandemic we need to strengthen our system by increasing resources and and increase capacity to respond in an emergency. "We believe that adding pharmacists to the list of people who are able to immunize will help address this issue. A lot of people regularly visit pharmacies. They trust their pharmacists and look to them for information. We have held flu clinics at local pharmacies in the past and we have had a very good turnout. We are in favor of this pilot and attempting to expand our collaborative route to pharmacies in Massachusetts. Twenty-five other states are already instituting this type of campaign", concluded Ms. Cheney.

In conclusion, Dr. Carrow stated, "The pilot project itself is a step in increasing access by individuals to vaccinations. The Department and the Board of Pharmacy have together designated about a dozen pharmacies in the state to participate in the project. The pharmacists will be trained by the American Pharmacists Association's Immunization Training Program, which has received the endorsement of the Center for Disease Control…."

Proposed changes to 105 CMR 700.000 by inserting the following new section:

(a) Such registered pharmacist is authorized to dispense controlled substances in accordance with M.G.L.c.112;

(b) Such administration is conducted pursuant to the order of practitioner; and

(c) Such activity is conducted in accordance with guidelines adopted by the Department which shall include, but not be limited to, requirements for:

1. Training accredited by the Centers for Disease Control and Prevention, the American Council on Pharmaceutical Education or a similar health authority or professional body; and

2. Pre-administration education and screening, vaccine storage and handling, administration of medication, record keeping and reporting of adverse events.

NO VOTE/INFORMATION ONLY

INFORMATIONAL BRIEFING ON AMENDMENTS TO TOBACCO REGULATIONS (105 CMR 660.000 AND 105 CMR 665.000):

Dr. Gregory Connolly, Director, Massachusetts Tobacco Control Program, gave a slide show presentation to the Council on tobacco and information on proposed regulations. Dr. Connolly said, "Massachusetts was a signatory to the master settlement agreement and our Attorney General put in stipulations that the tobacco industry would not target children with their advertising following signature of the agreement. Last week, we issued a report where we have been tracking cigarette advertising throughout the country and regretfully found the tobacco industry, after being forced to take billboards down because of the agreement, has recycled the money to many magazines read by young people. The Department will continue to closely monitor the marketing of tobacco products in the state, in the country and work closely with the Attorney General to make sure the tobacco industry doesn't violate the provisions of the agreement. A second point I would like to raise with the Council is the Department has just launched a new initiative educating smokers in the state about lung cancer. Lung cancer is a disease that was extremely rare at the beginning of this century. It ranked in a 1928 Department report as the sixth most common cancer. Today it's the most common cancer among men and women, with a five year mortality rate of 85% in five years. In a sense it's the hidden cancer. It's the cancer that doesn't get attention. It's one where smokers in denial refuse to accept the risk factor that they have for cancer."

Dr. Connolly continued, "The advertising puts a face on numbers and each year 3,000 families in the state regretfully lose loved ones from lung cancer. And I think by and large it is again the disease where there's no marchers. It's a disease where people know very little about their risk, know little about the mortality, and it's a disease caused by tobacco companies. It strikes every family in the Commonwealth, and we will aggressively conduct an educational campaign around the issue of lung cancer over the next years with the hope that we will see a decline in its incidence among women. We don't expect we will until the year 2004, at this point in time. In keeping with that, we have been aggressively requiring tobacco manufacturers to better inform consumers, scientists and public health agencies about how their product works. It's one of the few consumer products where no one knows what goes in it, no one knows what comes out of it, no one knows how it's designed to cause or maintain addiction. In keeping with that and implementing the Tolman Act, we have conducted three initiatives. One is to better determine how much nicotine is delivered by the tobacco product to the consumer. We did that through regulations two years ago, where we required manufacturers to reset the machine settings on how a cigarette is smoked. The settings were set by the federal government over 30 years ago. They do not reflect how much nicotine actually is delivered under smoking conditions today. People smoke much more intensively."

"The manufacturers," continued Dr. Connolly, "complied with that and have filed annual reports with the Department for the past two years. We are estimating that the average consumer gets about twice or three times a dose of nicotine than what's reported on the package. One difficulty with that report is it doesn't take into account what actually gets into the body. A machine setting really is an artificial condition. We are proposing to amend the regulation to first get a lot more information about the product itself that we are not

reporting. We are going to ask the companies to report ten or fifteen new variables that no other public health entity in this country gets. Second, to conduct a machine testing on a sample of 75 brands that we think reflect the marketplace. And that would be the current machine testing, which is more intense than what the federal government requires. And then third, we are going to require manufacturers to obtain exposure measures that would be urine cotinine for a sample of 15 brands. And we will control for a nicotine level in the machine test. In doing so, we will be better able to estimate how much nicotine is actually getting into the body of the consumer, based upon obtaining human exposure data. This has been recommended by advisors to the Department of Public Health. It will be the first time in this nation where manufacturers of tobacco products are required to report to a public health entity how much nicotine is actually ingested by the human. Another item that we have worked on is obtaining a list of additives from the tobacco industry. The Commonwealth and the Department have been sued by tobacco manufacturers claiming that release of the list to the Department represents a 'takings' claim. We were enjoined by the federal court from receiving that list approximately two years ago. Summary judgment motions have been filed by the Commonwealth and by the tobacco companies about 18 months ago on this claim and the court has yet to rule. We are disappointed in the slowness of that action by the federal court. We have amended the regulations though to address some of the concerns of the tobacco industry relative to protection of the list. We think if we could present amended regulations to the court that it may strengthen our case."

Dr. Connolly said further, "The third and final area that the Department has been working on is requiring the tobacco companies not just to report tar in their brands, and in many cases they are calling it light tar or low tar, and people then smoke those brands, somehow thinking they are safer. But to report the major fodder to constituents in tobacco smoke: formaldehyde, acrolein, acetaldehydes, N-nitrosamines, toluene. We think this information is important because (1) you can then quantify the toxic constituent in smoke and better educate the consumer about the fact that there is formaldehyde at a particular level in your Marlboro Light 100s; (2), we can encourage scientific research into what's in the smoke; and (3) possibly promote competition among manufacturers to lower or remove certain constituents, as they are doing right now with N-nitrosamines. We proposed that approximately eighteen months ago. The cigarette manufacturers came back to the Department and said, let us do a benchmarking study, which they did for the Department. They studied 26 brands, attempting to correlate tar, carbon monoxide and nicotine with gas phase or particular phase matter in the smoke. That is to say if we know this tar level, we can tell you how much nitrosamines are present in that particular brand. We have received the report. It's 20,000 data points. It's being analyzed by our consultants and our advisors. But we think it is a very important step for tobacco companies to take and to have made to begin to really do a much better job in terms of reporting how their product performs. As with the nicotine though, just by measuring the toxic constituents in the smoke, you don't know what goes into the body. So as we test for exposure to nicotine with those sample of 15 brands, we are recommending that we test metabolites of two known human carcinogens: NNAL (a metabolite of NNK) and benzopyrene (BAP), and measure that also within the urine of smokers of those brands. Again, by correlating the exposure for those

constituents, we think we can deal with the issue of compensation and better inform consumers that the claims of this cigarette being light or ultra-light just aren't valid claims. We also think by doing that we could possibly promote consumers to think about using therapeutic agents to quit such as inhalers, or patches or gum versus agents with now toxic levels. And also to encourage the scientific community to do more research into how a cigarette performs, toxic properties of the smoke, and so on and so forth."

Chairman Koh concluded with, "…As Dr. Connolly said, it is really up to the states like Massachusetts to take the lead. I'm delighted that we are doing this as public health professionals. Underscoring the fact that lung cancer is our number one cancer killer in women and men. I think most people don't still understand that and that 90% of it is preventable. That these amendments today are proposing to see how cigarettes affect the health of humans, not the effect of machines that are testing these cigarettes and the constituents." Dr. Koh noted how important counter advertising is in terms of educating the public, and changing the social norms and finally that the tobacco settlement has simply reshuffled the advertising money and not settled anything. "I really want Massachusetts to finish the job that we have started because we still have the fastest decline in cigarette consumption in the country and one of the best anti-tobacco programs in the world," stated Dr. Koh.

Council Member Rubin stated that he liked the touching ad but that the wording should be larger. Dr. Askinazi made general comments, stating that he liked the ad also. In response to Dr. Askinazi, Dr. Connolly noted that Arnold Communication in on contract with the Department to create the anti-tobacco campaign.

NO VOTE/INFORMATION ONLY

DETERMINATION OF NEED:

COMPLIANCE MEMORANDUM: PREVIOUSLY APPROVED DoN PROJECT NO. 2-3956 OF HEALTHALLIANCE HOSPITALS – PROGRESS REPORT ON COMPLIANCE WITH CONDITIONS OF APPROVAL FOR TRANSFER OF OWNERSHIP:

Council Member Janet Slemenda recused herself from discussion of docket item No. 4 (Previously Approved DoN #2-3956 of HealthAlliance Hospitals).

Dr. Paul Dreyer, Director, Division of Health Care Quality, began the report, "We are here to present the third progress report to the Council regarding the status of HealthAlliance Hospital's compliance with condition #12 of the approved DoN from Project No. 2-3956 which, in turn, incorporated conditions from an earlier DoN No. 2-3925….The Council originally approved the condition on October 22, 1996. This is condition No. 5 of DoN 2-3925. The condition required HealthAlliance to establish and operate via a special project approval, a satellite emergency department capable of receiving unscheduled basic life services transport via unscheduled ambulance. It set out procedures for HealthAlliance to

follow in the event that HealthAlliance determined that it needed to reduce the scope of those emergency services at the Burbank campus. HealthAlliance has determined that it needs to eliminate the 11 to 7 shift which would effectively transform the satellite emergency department into an urgent care center that would not be able to accept unscheduled ambulance transport." He said the Council's role here is to determine whether HealthAlliance has appropriately followed the procedures called for in the condition.

Dr. Dreyer further said, "Staff has reviewed all of the submissions of information from HealthAlliance, elected and other officials in Fitchburg and related communities, and the Northern HealthCare Coalition. We did not find that the closure of the 11 to 7 shift at Burbank would have a major impact on the health of residents of Fitchburg and the northern tier communities. All of the experts with whom we have discussed this issue within many contexts agreed that for people with life threatening emergencies, the right place to go is a full service hospital that can provide definitive care. In this area, the hospital patients are and should be going to Leominster Hospital for serious intervention." Dr. Dreyer noted that urgent cases that go to Burbank during the day can continue to do so (11:00 a.m. to 11:00 p.m.). The night shift walk-in cases and ambulance transports that currently go to the Burbank Campus after 11:00 p.m., could be handled at the Leominster campus." In closing, Dr. Dreyer stated that all the parties need to work together to ensure that the urgent care center will be used to its maximum capacity – that is that all non-emergent medical conditions that can be treated there, go there for treatment.

Attorney Carl Rosenfield, Deputy General Counsel, Department of Public Health, addressed the Council. He gave the Council background information on the 1996 DoN and stated in part, "In the 1996 condition, no. 5, I think it is clear that the condition specifically lays out the process that has to be followed prior to them implementing their decision to curtail services at the Burbank site. It is clear that that was intended to be the only process that needed to be followed. By its terms, looking at the specific language, the condition is self-executing. It says yes, you have a commitment to provide emergency services at that site, provided that the Department approves your special project application. But if you decide that you want to curtail that to any extent, then you have to follow that process prior to doing so. It doesn't say prior to coming back to the Department. It says prior to doing so. I think the words are clear and they are entitled to be interpreted according to their plain meaning. If you look at condition no. 5 in its totality, in the context, I think the conclusion is that, yes, there is a report back to the Council today, but no amendment and vote is required."

Mr. Jere Page, Senior Program Analyst, Determination of Need Program and analyst for this project presented his report to the Council, which had been sent to the Council, prior to the meeting for review. He stated that all eleven conditions of the approved 1996 DoN application have been met. They include, statutory free care, Regional EMS (emergency medical services), financial investments in the Burbank campus, governance, non-emergency transportation, free care services, interpreter services, mental health, education/outreach efforts, and outpatient services at the Burbank campus.

Dr. Jonathan Robbins, President and CEO of HealthAlliance Hospitals, Inc., accompanied by Dr. Arthur Russo, Executive Vice President and Chief of Operations at UMass Memorial Health Care Systems, Dr. Jonathan Jones, Chief of Wachusett Emergency Physicians, and Ms. Jill Lyons, Director of Ambulatory Care Services at HealthAlliance. Dr. Robbins stated, "…that the decision to reduce the scope of the satellite emergency room really developed over the winter, when initially we discovered that we had staffing problems which we felt were due to chronically low census. That triggered an intensive study of how we were delivering the care in our region….Ultimately, this is a discussion regarding the appropriateness of care settings and is also a discussion of allocation of resources, both human and financial."

Ms. Lyons, R.N. made a slide presentation and said in part, "I'm here to do a presentation on the proposed changes that HealthAlliance has proposed to the satellite emergency center. There are several facts that were taken into consideration during this difficult decision. There's a 5.2 mile distance between the Burbank and Leominster campuses; there is an eight to ten minute travel time during the night shift; 92% of the cases that we see at the Burbank campus are non-urgent conditions. We are seeing about 15 BLS ambulances at night, during the month. Some of the reasons for closure are difficulty in recruitment and retention. Presently, we have 100% vacancy for nursing staff on the night shift. We have lack of volume – 5.7 cases at night, most of them non-urgent. There are financial issues. It's very costly. We want to appropriately place our patients and our services. We really do not want serious cases going to the Burbank campus. We would rather have the serious cases at Leominster, where our services are and inpatient facilities are located. The top ten diagnoses of the patients that we are seeing at the Burbank campus are as follows: ear infections, simple lacerations, bronchitis, upper respiratory infections, viral illnesses, sprains, abdominal pain, anxiety, back pain, and simple fractures. Some of our analysis that we did before this decision was made is that public safety certainly will not be compromised by this decision. There will be enhanced treatment of the mentally ill population. We have met with the triage clinicians that presently see the emergency psychiatric patients on the Burbank campus. They rotate between Clinton Hospital, which is south of Leominster, Leominster Hospital and Burbank. Their feeling is by having all the mentally ill, the psychiatric population come to one campus, assessment will be enhanced. The delays that we presently see waiting for a triage clinician to come from one hospital to another will be eliminated. There will be improved utilization of physician services. We will be able to bring the physician that presently is working on the night shift, over to Leominster to work the peak hours that we have. The basic character of the types of cases seen will not change. Basically what goes there now is urgent care and therefore, the general public should not notice the difference." The rest of Ms. Lyons presentation provided the following information (in brief):

- Of 15 ambulances that come per month, 75% or more come from Fitchburg. Just a few come from the northern towns. One to three ambulances per month come from the northern towns.

- Ambulances that arrive during the 7a.m.-11p.m. shift is 2.1 per day. Those two ambulances could be brought to Leominster with no problem. Ninety-four percent of the cases that presently come to Burbank are walk-in cases; 6% come by ambulance.

- Nine psychiatric patients per month are seen at Burbank, of these 18% are admitted.

- 5.5 substance abuse patients per month are seen at Burbank. None of these have been admitted to Burbank or Leominster. They have all been transferred to detox centers for treatment.

- The average number of patients seen at Burbank during the night shift each month is 5.7.

- At the Burbank campus, there is a low of two patients per month and a high of 12 patients per month that arrive with urgent (need to be seen within an hour) conditions such as asthma and chest pain. Ninety-two to ninety-four percent of the patients are non-urgent in nature.

- A Task Force has been formed with the local EMS population.

- HealthAlliance meets regularly with the Northern HealthCare Coalition (usually monthly).

- HealthAlliance met with the following Fitchburg entities: Mayor, City Council, police department, a member of the fire department, and superintendent of schools. As a result, a steering committee has formed to address the needs of the community, which will continually do community need assessments.

- The urgent care center at Burbank will be operated as a family medical care center, operating 365 days a year, 7 a.m. to 11 p.m., providing patient focus care, referring patients that require emergency treatment to Leominster Hospital. The staff will be board certified emergency trained physicians, physician assistants, nurse practitioners and registered nurses. Non-urgent services will include: colds, flus, sore throats, ear infections, physicals, flu and pneumonia vaccinations. Other than the Urgent Care Center there will be outpatient clinics, the Take Charge program, which is occupational health services, an infusion center, cancer center, lab services, physical therapy, audiology, radiology, mammography, bone densitometry, respiratory therapy, a 15-bed psychiatric unit, a partial psychiatric program, a cardiac rehabilitation program, a women and infant program, and Fitchburg Family Practice and the Highlands Long Term Care.

In conclusion, Dr. Robbins stated that he feels that they have completed the process. They have made themselves available to anybody who wanted to meet with them – attended every meeting they were invited to and have been on the radio. Discussion followed, whereby the Council asked Dr. Robbins questions. The Commissioner asked Dr. Robbins

about delaying the changes at Burbank until September when the expansion at the Leominster Facility is up and running. Dr. Jonathan Jones, responded to this question by saying that the Burbank site is not an emergency department but rather an urgent care center and that it is dangerous to the public to persist in this allusion that Burbank is an emergency department. "It is a disaster waiting to happen," said Dr. Jones. Dr. Koh responded by stating, "that one could argue that they have been running this emergency department for 30 odd months and to extend it another month or two would be a sign of maximum communication with all the parties involved." Dr. Robbins added that they do not have the nursing staff to cover the summer months. He said, "If it were easy to do, I would certainly opt to do that for obvious reasons, but I feel it would create a hazard."

Attorney Clare D. McGorrian, Health Law Advocates for the North Health Care Coalition testified next. First Atty. McGorrian asked Council Member Sherman to abstain from making a decision on this matter due his close affiliation between UMass Medical School and the DoN applicant. Council Member Sherman declined, stating that M.G.L. Chapter. 268A.s.7 states that direct or indirect financial interest would be cause for him to abstain. He has neither and would not recuse himself from discussion or voting on this matter. Attorney McGorrian said in part, "…DoN 2-3925, the 1996 DoN, which contains condition no. 5 that requires the establishment of the satellite emergency center, is what the Coalition is concerned about today." She noted that all the conditions should be brought back in six months to the Council which staff has proposed. Attorney McGorrian stated, "In DoN 2-3925, this Council required HealthAlliance to provide 24 hour, 7 day per week emergency services in Fitchburg. HealthAlliance, UMass Memorial HealthAlliance has operated a 24-hour a day emergency service at Burbank since March 1998, under the satellite project. Just last November, at HealthAlliance's own request, this Department extended the special project approval to run that satellite ER for two more years. Now HealthAlliance wants to turn the Burbank Emergency Room into a 16 hour per day urgent care center. The Northern HealthCare Coalition completely opposes this proposed change. We ask that the Council reject the DoN staff recommendation in favor of this change for two reasons. First, the process leading up to the DoN staff recommendation has been seriously flawed. Second, on a substantive level, HealthAlliance has failed to demonstrate despite their lovely slide presentation, that an urgent care center will meet the needs of the community. Substantial evidence submitted by the Coalition and other prominent community members, including the City Council show that closure of the Burbank Emergency Room will likely be harmful to the public and greater Fitchburg. The Northern HealthCare Coalition and its Counsel helped draft and negotiate condition no. 5, that is the condition that required the satellite center. And the Coalition has monitored HealthAlliance's compliance with that condition since the beginning. We have actively contributed, as you all know because you have seen us here before at status updates to this Council. Two weeks ago, the coalition submitted detailed comments and extensive supporting documentation to the DoN staff in opposition to HealthAlliance's plan to eliminate emergency services at Burbank. Prior to that, we had met with Paul Dreyer, his staff and DPH legal counsel to discuss concerns about this plan. Despite the apparent inclusion of the Northern HealthCare Coalition in the review process, we feel that the Department has paid mere lip service to the community's concerns. If you look at the staff report that was prepared it does not give serious

consideration to the Coalition's concerns. They ignored large portions of the Coalition's arguments and supported facts. An example is HealthAlliance's assertion that emergency cases are few and far between at Burbank – if you look at HealthAlliance's chart, it shows that 30% of the cases are unaccounted for. They don't have a designation urgent or non-urgent, or emergent. It's unknown. It's hard to understand how HealthAlliance can come before this body and assert that there is no acuity when front line staff in the ER who we have spoken with and who are afraid to come here because of their jobs, have told us quite differently. In addition, the staff report failed to enclose the eleven substantive exhibits that the Coalition submitted. However, we sent them to you directly from our office so you should have them. We ask the Council on the process grounds alone, reject the DoN program recommendation. We feel that there has really been a lack of fair and adequate process. And at a minimum that you not make a decision today to allow time for a full and fair process to be completed. We do intend to appeal a ruling in HealthAlliance's favor if that goes that way today because we really feel this process has been incomplete."

Attorney McGorrian continued, "The second process concern has to do with HealthAlliance's failure to comply with the DoN amendment requirement. This is a legal argument. As you know, Attorney Rosenfield, Legal Counsel for DPH contends that HealthAlliance need not seek formal amendment of condition no. 5 before reducing services at Burbank. We strenuously disagree…Condition 5 expressly require 24 hour a day, 7 days a week operation of the Burbank Emergency Room. The condition sets forth detailed requirements for that satellite emergency room. It is true that special project approval was also needed to fill out some of those details but the condition itself is explicit that there be 24 hour emergency services there…We argue and feel that we have a good and strong argument on this, that the DoN regulations themselves require formal amendment of the DoN to eliminate the 24 hour requirement. I have to say that it is hard for me to understand why the Department is so vehemently opposed to that. I think if you look at the condition in the light most favorable to the public health in the community that negotiated it, that is the fairest way to go. And it really doesn't make sense to deny that. Again, we ask the Council to deny the request to close down the ER at this point. We think that HealthAlliance has to come back and do a formal DoN amendment process. We should also note that we would plan to appeal the denial on that basis. Finally, we disagree with the DoN Program's conclusion that HealthAlliance has completed the five steps laid out in the Condition. We think those are supplemental to the DoN amendment process. We acknowledge that they have done quite a lot toward meeting them and they have met with the City Council, the Mayor. They did apparently send notice to all communities in the vicinity. But HealthAlliance rests its lack of meetings with any community other than Fitchburg or Ashby on the grounds that they didn't call us. They didn't contact us. We strongly feel that in this situation, where the community's health is at stake, UMass Memorial HealthAlliance has the burden of insuring that all community voices are heard. And they have the burden of seeking out and making sure that there is no need for a meeting."

Attorney McGorrian noted that the May 10th letter from HealthAlliance to the DoN program with the written explanation of the planned reduction is inadequate. That DoN staff has

merely reiterated without any factual support, the letter of HealthAlliance's. Attorney McGorrian said, "They owe [HealthAlliance] the community a full and fair explanation in this final report – something more along the lines of the 90 day report they did when the hospital closed the full service ER several years ago…In addition to obtaining the Council's approval to amend the condition, UMass Memorial HealthAlliance must complete the process outlined in condition no. 5, in letter and in spirit, before this Council should allow the reduction of services."

In conclusion, Attorney McGorrian noted, "Fitchburg has a poor and medically needy population that uses the Burbank Emergency Room. Poorer and larger than Leominster and that greater area. This population has significant public health problems, including high incidences of death from substance abuse and AIDS, and mental illness and suicide. There's a serious omission in HealthAlliance's charts that were presented today about the mental health component of the services provided at the Burbank ER including on the night shift. To say that these people will be better served when they arrive at the emergency room or at the Burbank campus and find that there is only a 911 phone in the parking lot is I think offensive to people and their families who have severe psychiatric illness. The other issue is people living north of Fitchburg are geographically isolated with respect to ER services….and the staffing problem is a red herring from what we heard from the nurses that we have spoken to. There is no evidence of a safety problem. The applicant is saying on one hand 'there is a disaster waiting to happen' and on the other hand saying nobody shows up at the Burbank campus for treatment. The Coalition is deeply disturbed by HealthAlliance's plan to close the Burbank Emergency Room and the Department's lack of fair process at the DoN staff level in considering the communities concerns. UMass Memorial HealthAlliance made a commitment to the success of the emergency service at Burbank. This Council relied on that commitment in approving the prior DoN's, and HealthAlliance should make good on that commitment. We ask that the Council exercise its authority to fulfill the mission of the Department which is, in part, to dedicate it to the health concerns of vulnerable people, including those poor and needy people of the City of Fitchburg, and to not allow this to happen at this time."

Ms. Kathy Sicard, President of the Northern HealthCare Coalition, addressed the Council. She asked Chairman Koh if he viewed the tape of the public meeting in Fitchburg that she had sent him. He replied that he did not see the tape but that staff was in receipt of the tape. Ms. Sicard said that the public meeting was held in April at the Civic Center and over 200 members of the community attended. Ms. Sicard's presentation made the following points:

- The Coalition strongly objects to the elimination of the 11 to 7 shift at Burbank and believes that more than five patients will be impacted by this action.

- The Leominster Campus Emergency Room is already over burdened with patients and has a long waiting time. "On Sunday, May 7, several patients left the Leominster Campus and went to the Burbank Campus with their triage charts in their hands

because of the long wait at Leominster."

- No public education has been done as to what an urgent care center is and what the scope of services will be. And further, whether your insurance will cover costs at such a center. "This public education must be done before any further reduction in emergency services can safely take place."

- UMass Memorial HealthAlliance distributed to 8,000 residents, a physician's directory. In the directory it stated that 'emergency services are provided on both campuses'. "To advertise emergency services on both campuses and then suddenly rush to turn Burbank into an urgent care center seems reckless."

- "It's common sense that it takes longer to get to the Leominster ER than the Burbank Emergency Room from Fitchburg and the northern tier communities. UMass Memorial HealthAlliance runs a newspaper ad in Worcester which, states that 'one second counts'. "If one second counts in Worcester it should count in Fitchburg and the northern tier communities." Ms. Sicard described a serious multi-automobile accident that occurred on April 19, the Leominster ER was 13.5 miles from the scene of the accident and the Burbank ER was 3.4 miles from the scene of the accident. She said, "Time does make a difference."

- The dedicated nurses of the Burbank Emergency Room submitted a letter to UMass Memorial HealthAlliance pledging a staffing plan of twelve hour shifts that would alleviate the majority of the staffing problem there. Ms. Sicard said, "Almost any problem can be solved but first you have to want to solve it, not eliminate it. As far as low recruitment, would any of you apply for a position if you were constantly being told it is going to be gone in the next month or so. You can't say that you are honestly trying to recruit people when you keep telling them the position is going away…"

In conclusion, Ms. Sicard said, "We do have concerns with the role the Department of Public Health has played in this process. Perhaps naively, we have thought of the DPH as a safety net for our concerns. If these concerns are not the role of DPH then whose role is it? We have asked the Department staff for suggestions as to how to preserve emergency services and feel our requests have largely been ignored. We believe we need to grow this service, not eliminate it. We are also concerned that the change in the condition regarding the ambulance bay that was said to be at the Burbank Campus never occurred. There was a conversation between DPH and HealthAlliance and then suddenly the ambulance bay is in another position. The Coalition or its Counsel was never formally approached by DPH as to how this change or why this change had taken place and we really don't understand why we were not more of that process." Ms. Eleanor Gilmartin of the Northern HealthCare Coalition, said that she concurred with everything that's been said by Sicard and McGorrian.

Council Member Sherman replied to the Coalition and their Counsel's remarks by stating the following:

- One should not expect more from the applicant than they already have done in regards to notifying all the cities/towns about the proposed change at the Burbank Campus.

- The issue of the nurses being afraid to come forward because they may lose their jobs is a red herring.

- "If the Department of Public Health is a safety net for the people of Massachusetts, it is also a safety net for the people who work in and with the hospitals. I'm trying to say the party is over for giving everybody everything—the pie is being cut in too many pieces and it is still an 8" pie and not everybody can have everything and accommodations must be made. Whether these are accommodations or not, I feel comfortable that the process was followed…I'm looking at this very objectively….There's no financial interest to me…."

Attorney McGorrian noted that she felt it was unfair that the Coalition didn't receive any data that the Department said they relied on to make their decision regarding the mentioned experts and they received no written data on HealthAlliance's slide presentation. Attorney McGorrian stated that using HealthAlliance's own data – a pie chart indicates that 30% of the cases for the night shift (between December of last year and February of this year) have no designation so the information of 5.7 cases at night is inaccurate. Chairman Koh, Atty. Levin, and Atty. McGorrian debated about the 1996 DoN condition, which explains the steps that the applicant must take to downsize the emergency room. Staff said the condition is self-executing and Atty. McGorrian said that the DoN Regulation 105 CMR 100.750 states that modification of a condition in an approved DoN is a significant change which requires Public Health Council approval requiring this applicant to go through that process.

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For the record: At approximately 12:05 p.m., Dr. Askinazi and Mr. George left the meeting during the HealthAlliance presentation. Five members remained as follows: Chairman Koh, Dr. Sterne, Mr. Rubin, Ms. Slemenda and Ms. Masaschi.

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Chairman Koh asked Ms. Sicard what the tone of the local meeting was about this issue. A community spokesperson said, "I've been involved for many years in other kinds of advocacy projects, and I can't remember an occasion where there was such an outpouring of individuals, people, public sentiment, and people who are known in the community. The hearing was facilitated by the City Council who as a whole objects to the closing of the shift at the ER. But, there are other people, the superintendent of schools spoke and he is outraged. He is very concerned because of the number of people going to the new high school which will open in the fall, north of Fitchburg. That was the tenor of the night. It was

public outrage. The hall was full to overflowing and hundreds more watched on cable TV and commented afterwards."

Chairman Koh noted that 5.7 patients on average during the night shift are not a viable setting to do any sort of health care business. Atty. McGorrian replied that the low census could be improved with efforts on HealthAlliance's part. She said, "There has been so much misinformation so much discouraging of patients going there, and physicians' own practice patterns, which have not been changed. HealthAlliance says they have made efforts but we don't feel that they are adequate. Further, since Burbank facility isn't a full service ER facility, many cases can't be brought there by ambulance."

Dr. Thomas Sterne, Council Member stated in part, "…There are two general issues on the table (1) Whether or not in the legalistic sense the Alliance is entitled to make an alteration at this point based on the original description of condition #5 of the 1996 agreement, regardless of what one thinks about the quality of the alteration. The second question has to do with the consequences of an alteration, should it be made….It's important to acknowledge in the second part of the question, if there is an alteration to be made, that current public perception about the services - the extent, scope, quantity and quality of the services - available on all three shifts will then be, for at least some period of time, operating under a set of misconceptions. In the eye of the consumer, a switch from an emergency facility to an urgent care facility, unless it is totally clear what the urgent care facility has during its time of operations equal capability to its previous designation, people will be operating under some degree of confusion about the scope of the services that are available."

Dr. Sterne continued, "In regard to the first part, there seems to be adequate protection for the Institution to make change by the way the provision was written, the DoN regulations in general notwithstanding. In the second part, that there would be no particular compelling reason for me to encourage rushing it through with regard to the timing of an alteration, should the Council, as a group, agree that a change was allowable. And that time for transition – issues of staffing, notwithstanding. And that time might conceivably be allowed to forward a transition, as per Commissioner Koh's implied request."

Ms. Stacy Ober, Assistant Director of Massachusetts Nurses Association, addressed the Council. She said in part, "I'm here to validate the testimony that you heard earlier that, in fact, nurses are intimated and fearful about talking in relation to staffing at the Burbank Campus. It has to do with a written reprimand that was given to a nurse that I know of who actually had spoken external to the facility about staffing. I like to share with you that our members have reported to us that, in fact, the Administration has encouraged them to look for jobs elsewhere because this particular unit would be closed. I want to share that perspective with you because it underlines this rationale that, in fact, poor staffing led to low census and therefore the need for this analysis. It is really putting the cart before the horse. Nurses were told go get jobs elsewhere. We are going to close this unit." Ms. Ober informed the Council that there is a great distinction between an emergency services and urgent care center. The former must adhere to federal statutes and requires certain

responsibilities. Ms.Ober said she felt HealthAlliance was trying to sidestep these responsibilities by calling itself an urgent care center.

Ms. Gloria Graven, Director of Legislation, Massachusetts Nurses Association, also addressed the Council. She said, "The Massachusetts Nurses Association and the nurses of that bargaining unit are more than willing to sit down with HealthAlliance management to address ways of staffing that unit 24 hours a day. I can tell you with no uncertainty that they have not been approached with this issue and have been asked to address this issue. If that is their concern there is a mechanism to address it." Ms. Craven shared her experience in the Malden, Melrose and Winchester area where there is now only one emergency room, which cannot handle all of the influx of patients. The firefighters have to divert patients as far away as Burlington.

Mr. Daniel Mylott, President, Fitchburg City Council, testified before the Council. He said his law department has given an opinion on condition #5 that are similar to DPH's Counsel decision – it does have pertinent differences. One is condition #5 describes the process to follow if it determines that it may need to consider reducing the scope of emergency services described therein. We agree that that's what should be done. We also believe that the decision had already been made to close the 11 to 7 shift. So it was no longer in the purview of deemed to consider. And we think that is important because we look at this condition as one of community involvement. That is when the Committee decided to allow this to take place, what you asked us all to do was to get together and talk about this and come up with the answers together. That has not occurred." Councilor Mylott stated that Dr. Robbins has met with them and has been courteous but feels that the discussion of public safety has just not been thorough enough. Further, he said that the five mile trip from Fitchburg to Leominster takes about twenty minutes during rush hour and other busy times of the day, eight minutes at 2:00 a.m. in the morning perhaps. "It is a great public safety issue", concluded Councilor Mylott.

Mr. Paul F. Fontaine, Vice President, Fitchburg City Council, addressed the Council. He gave population figures on the area and said, "I know some of you may think that this issue is not within your purview or within your authority to act on it. But it's my understanding that any matter that is a potential risk to public health is clearly within your purview and within your power to take action. We would like to see the Public Health Council say no to their request to close down this third shift. And in the least case, to be as intelligent as Dr. Sterne was to say put off the decision until more information can come forward through an independent study."

In closing, Councilor Fontaine stated, "I think your DoN staff, as good intentioned as they are, were clearly off the mark with the advice that they are giving to you. I think you deserve to get better advice, more independent advice, and see what kind of impact this would have to our community of 80,000 folks. And if you would be willing to do that, we certainly would support you in that effort because you do have the power and the authority to take this kind of action."

Mr. Kevin Roy, Fire Chief of Fitchburg, addressed the Council and said in part, "I have been on the Department for 25 years and we have been responsible for pre-hospital care in the Fitchburg area and for ALS care in the northern communities. He cited statistics showing that most people have been going to Leominster Hospital and not Burbank Hospital for various reasons, one being people's physicians directing them to go to Leominster's Emergency Room, not Burbank's." Fire Chief Roy said that the pilot program has not been given a fair chance to work. Ninety-five percent of the ambulances are going to Leominster, which is increasing response time by ambulances because of the longer trip back and forth to Leominster from Fitchburg and the Northern Tier communities and the paperwork.

In closing, Fire Chief Roy said, "I would ask the Chairman that we be given some more time here. In fact, I think the satellite emergency program should continue and that a better effort be put on directing the patients and ambulances to be sent there [Burbank Campus]. In the meantime, we are trying to establish a pre-hospital plan, but it will once again come down to dollars and cents between all the parties involved."

Chairman Koh summarized the situation, "I think you have heard an example of health care in transition and some of the very challenging issues on so many levels of what happens when emergency facilities merge or the possible closure of even one shift is discussed. There are many issues that come in front of this Council and in front of Public Health authorities with regard to quality of care and access in an incredibly shifting climate that we are facing here. And this is just one example. Let me also stress that of the 11 conditions that were put forward in 1996, there is agreement on 10 of them. That's progress and that couldn't have happened unless there was good communication and discussion from all the parties involved. We are down to this 11th one. I think there are several questions that should be raised here. (1) Were the 1996 conditions met? And my reading of this memo and after hearing the arguments, my inclination here is that the conditions have been met. That in the second paragraph it reads that in the event that HealthAlliance determines it may need to consider reducing the scope of emergency services, and then there are five steps put forward, and those steps have been followed. That's my interpretation. I'd like to hear from the other Council Members. Having said that, there are clearly communication issues here and whether all parties have been heard and whether there have been good discussions and understanding. I think Dr. Sterne's comment about public education is a very good one. And the comments from some of the advocates about making sure that people in the community know what emergency facilities mean versus an urgent care facility, and making sure that that coordination and education goes well. What I'd like to put forward as a point of discussion here is to first say I believe the conditions have been met, as set forth in 1996. But having said that, the communication here needs to be improved. I would like to ask Dr. Robbins again whether he and staff would consider delaying closing down this night shift until September, until Leominster is totally up-to-speed. And that would be a step in terms of a good faith compromise, if you will, on this issue. And that also between now and September that there be intense community discussion involving steering committees, all the groups involved here at the community level, so that when September comes, we will be ready for an appropriate transition that will be seamless."

Dr. Sterne commented, “I support Commissioner Koh’s request, and that included in that request, that time be spent over the ensuing several months in accomplishing a number of small alterations. The printed data from the University of Massachusetts with regard to facility capacity needs to be altered and promulgated. The communities need to then understand the scope of what will and will not take place in Burbank come transition time. And that intense effort be made likewise between the communities involved and the facility to organize a pre-hospital movement plan that, adequate to both parties, addresses the issues of expense, time, deployment and triage regarding the patients that currently have access to Burbank. With those request in place, I agree with the Commissioner that I do believe that legally speaking the conditions have been met.”

Council Member Shane Kearney-Masaschi said, “I agree with Commissioner Koh. However, I am also concerned about the Fire Chief and his ability to have his people trained at a level so that they can make it, however many miles it is across town, to get the people where they need to go. I, too, live in a area where it is 25 minutes to my local hospital. So I feel for that and I know my Fire Chief well and I know that it is an ongoing issue with his daily job.”

Council Member Manthala George stated, “ I would agree with Commissioner Koh. I think it is extremely important for all the parties to continue to work together here. One of the comments that was made by one of the individuals that spoke here – the physician that was employed at the Burbank Center indicating that it is an urgent care center as opposed to an emergency care center, sort of raises a red flag in terms of the spirit of what the services should have probably been at the Burbank Center in the first place or the impression that people had in the first place. I believe that the staff at the Department of Public Health has interpreted the regulations and they did their research very appropriately and their conclusions are very appropriate. The critical piece is now how do you get from ‘A’ to ‘B’. I think sometimes you have to put the regulations aside for a moment and people begin to really work in terms of developing some sort of a compromise so that if it isn’t possible for that center to stay open, there needs to be ample time for transition so that virtually everyone understands that. I think that will take cooperation of both parties up in that area to do that. I think it would be a tremendous mistake to close that immediately, without taking into consideration the concerns the community has had. As the Commissioner said earlier, if there is an agreement on 10 of the conditions, there can be an agreement on the 11th, if everyone works a little harder at it.”

Dr. Koh responded, “What I am hearing from my Council members is that there is consensus that the conditions have been met, as set forth in the 1996 document. The need for further communication is tremendous here. There are a lot of issues regarding intense education that need to be addressed. Dr. Sterne has alluded to a number of them. The Council would like to ask HealthAlliance to keep the facility as it is until the Leominster Emergency Room’s capabilities are fully expanded, which is expected to be in September. There should be a lot more community-based communication on this issue from now until

then. Dr. Robbins, can you comment on that consensus?"

Dr. Robbins of HealthAlliance said, "I just want the Council to understand and differentiate between the highly emotional issue and the rational part. The rational part of this is at night we have 5.7 patients moving into a facility that on average sees 18 patients. There is no difficulty in terms of the physicality….We agree with Dr. Sterne that there needs to be an extensive public education plan put in place. But I beg the understanding of the Council that the staffing issues are real, in spite of what the MNA lobbyists tell you. And for six months, we aggressively tried to and were unable to fill those positions. And provided that I can maintain safe staffing on that facility. I will try to maintain the standard as long as I can. I do not want to plan a situation where on Monday, I wake up in the morning and find out on Tuesday night I have nobody to staff the shift. That would not be a good situation. Within those bounds, we will do our best."

Dr. Koh replied, "Thank you. I would really like to encourage every person who has testified today to really take the extra step in terms of communicating concerns and making this work over the next three months. These are very challenging issues and we have spent a lot of time on them today."

Attorney McGorrian, representing the Northern Health Care Coalition stated that they were pleased with the Council's recommendation and understand the legal arguments but feel they need something more solid that just HealthAlliance saying they will do their best. She said, "Something firm from HealthAlliance about how long they are going to take to do this and what steps are going to be in place. And we will come back before you and say we have done x, y, and z and now the community really knows what is going on and what we are going to provide there."

The Department of Public Health's General Counsel, Atty. Donna Levin added, "My notion is to ask Dr. Robbins if you can use the steering committee to address the points outlined by Dr. Sterne. Including printed data, UMASS, the community's need to understand the scope. There has to be an intense effort so that everybody knows what the status is come September. There has to be an organized effort, community involvement in organizing a pre-hospital movement plan addressing expense, time, deployment, and triage. If you can promise to do that, I think we can be on our way."

Dr. Koh added, "This steering committee needs to be expanded to involve whoever should be represented to address these issues. And you should meet regularly, weekly, biweekly, until we resolve these things."

Dr. Robbins of HealthAlliance stated, "The Council understands that the potential exists at this moment in time – I cannot make a statement and guarantee I can meet this."

Attorney Carl Rosenfield, Deputy General Counsel, Department of Public Health, noted, "When we met with the City of Fitchburg and HealthAlliance representatives last week, we talked about doing a number of things. There is already a planning group that's looking at

the pre-hospital provider side of this. I think there's been some acknowledgement that there needs to be some enhancement of the emergency services, especially in the northern part of that area. At the same time, we suggested to the parties that they expand their discussion to really start to look at the broader health care needs of the people who live in the service area and do some planning and ways in which they can better address those needs. It might be advisable to have HealthAlliance do the things Dr. Sterne is recommending but also to move squarely ahead with these other efforts. And then come back to the Council in October and talk about the transition of the satellite ED to a 16 hour urgent care center and also the progress of the other efforts that are underway to figure out ways to better serve the people in those communities."

In conclusion, Dr. Koh said, "Mr. Rosenfield is suggesting that we revisit progress on this and review what has been accomplished in October. Dr. Robbins, I understand the situation you are in and in my view and Counsel's view you have met the conditions. Having said that, you can hear the concerns of everybody here and the people they represent. I think to extend this just several more months would be an act of good faith that would be well received. And an opportunity to really have very intense discussions to address all the issues that Dr. Sterne and others have raised today. I think that would really help build some communication here that is sorely needed."

No Vote/Information Only

CATEGORY 2 APPLICATION: PROJECT APPLICATION NO. 4-1420 OF CAMBRIDGE PUBLIC HEALTH COMMISSION – new construction to replace the existing 179-bed Mayor Michael J. Neville Manor Nursing Home with a 112-bed facility to be located at the existing site

Representative Alice K. Wolf of Cambridge testified before the Council on Neville Manor Nursing Home. She said in part, "I'm here to ask you to support the Neville Manor petition for approval of their DoN. Neville Manor has for centuries provided assistance for infirmed people in the City of Cambridge. The need is even greater now than it was before. For those of us who are senior citizens, we are pleased that our life expectancy has gone up but it also means that there are more people who need care when they are seriously ill, either for an interim period of time or permanently. And by and large they are really sicker than they used to be. It's a little bit like the young children who we are able to save at very low birth weight due to our great advances, but at the same time that provides for some additional needs….The present building will be reconstructed for assisted living. That is not I know in your purview but it will be affordable assisted living, perhaps the first or certainly one of very few in the whole Commonwealth. This building will allow the Health Commission to provide the services which they have done very well so far, much more efficiently in a much better environment for the increasingly ill people in the city…Due to the location of this facility, this had to go through legislative approval. I'm happy to say that we were able to get the signature of the Governor. So this is well on its way and I very much

hope that you will support us in providing a great need for senior citizens in Cambridge and surrounding areas."

Mr. Jere Page, Senior Analyst, Determination of Need Program, presented the Cambridge Public Health Commission, d/b/a the Mayor Michael J. Neville Manor Nursing Home to the Council. Mr. Page said, "The applicant is before the Council today seeking approval to replace the existing 179 beds in Neville Manor with a new 112 Level II bed facility, to be located on the existing site. The recommended maximum capital expenditure is $9,535,783. A public hearing was held on this project on February 15 at the request of the Amy Nadel Ten Taxpayer Group. In the testimony presented at the hearing and subsequent written comments, the applicant's plan to locate the new facility on public land at Fresh Pond in Cambridge, the site of the existing facility is opposed. The taxpayer group asserts that more appropriate sites were available in Cambridge, including the previously empty Youville Nursing Home, and therefore there is no need to build a new facility at the existing site at Fresh Pond. The TTG also expressed concern about the proposed reduction in the number of Medicaid patients in the new facility, and whether the new facility will eventually become more of a private home than a public nursing home for people with limited income. As a remedy, the taxpayer notes that the Cambridge Public Health Commission has stated its commitment to maintain at least a minimum Medicaid census of 75% at the new facility and suggests this commitment be incorporated as a condition of approval by the Council. The taxpayer group is also concerned that the new $10.00 an hour minimum wage enacted recently by the City of Cambridge may impact the operating expenses projected by the applicant."

Mr. Page continued, "In responding to these concerns, staff notes that the issues raised regarding the site of the replacement facility are local issues and beyond the purview of DoN review. However, having said that, we note that the replacement is occurring on the site of the existing facility which has been there 70 years and the access concerns have not posed problems historically. Regarding the TTGs suggestion about the minimum Medicaid census at 75% under condition of approval, we note that the Division of Medical Assistance, that is Medicaid, had determined that there is no lack of access for Massachusetts Medicaid recipients actually since 1993. So given this and the stated commitment by the Cambridge Public Health Commission to the applicant to maintain that minimum Medicaid census of 75%, we believe that a condition for approval is not necessary regarding that particular issue. Regarding the TTGs concern about the $10.00 an hour minimum wage, staff notes that the applicant has included this minimum in its projected operating costs, and staff's analysis has found that the project is financially feasible and within the financial capability of the applicant. Therefore, in conclusion, we recommend approval of this project with the conditions listed on page 8 of the staff summary."

Mr. John O'Brien, CEO, Cambridge Public Health Commission addressed the Council. He said, "The Cambridge Public Health Commission operates not only Neville Manor but also the Cambridge Hospital, the Somerville Hospital, 23 neighborhood health centers and primary care sites in the two cities. We also operate the Health Department under a

contract with the City of Cambridge. I also serve as the Commissioner of Health for the City of Cambridge and proportionally, we are the largest provider of care to the indigent in Massachusetts. We need to replace the current facility. It's over 70 years old. We haven't done any major renovations for 25 years. We have 3- and 4-bed rooms, sometimes with one sink that has to be shared by all of the residents. The corridors are narrow. It is not great for our residents in wheelchairs. From the nursing stations you can not visually see all of the rooms or the residents in the corridors. And we only have two elevators in the entire facility for 179 residents. The mechanical systems are definitely outmoded, bathing areas are terrible, and our residents deserve better. The new building will address all of these issues - handicapped accessible bathrooms, one- and two-bed rooms with sinks, the resident rooms will be visible from the nurse's station and needless to say, state-of-the-art mechanical systems. We intend to build the 112 bed replacement facility. While it is not under the purview of the Council, we are also delighted about the fact that we are developing 71 units of affordable assisted living, and that will be a real asset in our community. We are very proud of that. There has been an exhaustive community process. We have been at this now for about five years. There have been dozens and dozens of community meetings. The City Manager actually appointed a site advisory committee that had very diverse representation from the community, including representatives of the community who were concerned about setting the facility up on the Fresh Pond Reservation. The City Council has been enormously supportive and they have unanimously approved and supported this effort, as has the Legislature, despite the fact that there is some continued opposition about building the facility."

Mr. O'Brien continued, "We have looked at the issue of moving to Youville. That is not possible. We are temporarily going to locate our residents there, but they have future needs for that building as well as the building that we are going to temporarily occupy is going to require a number of waivers. That wouldn't solve the problem. We are very proud of the community process that has gone on despite the fact that there is some small opposition. We have not brought the hundreds of community members and representatives from our delegation, and others who have supported this effort, given staff's recommendation."

Mr. Robert Healy, City Manager of Cambridge, testified next, "I've been the City Manager for 19 years and have been in the administration for 26 years. I'd have to say in that 26 year period, some of the highlights of my career have been amongst the success at Neville Manor and the services that it has provided to the citizens of the City of Cambridge, and others. This is the most exciting project that we have seen. The current building is antiquated but it is going to be reused and refurbished for a very good purpose. Affordable assisted living is something that Cambridge desperately needs. I also serve as the Chair of the City of Cambridge's affordable housing trust, and that is a project that has been well supported." Mr. Healy noted that there was an extensive community process and that about 98% of the community concerns have been resolved. He asked for approval of the project. Mr. Healy presented letters from Mayor Anthony D. Galluccio of Cambridge and himself in support of the project. Mr. O'Brien noted for the record that they are committed to public payor participation and have historically run well above 90% Medicaid, given their

payor mix. Further he noted that they have an agreement with the City and other parties to insure that at a minimum in perpetuity 75% would be public payor.

Mr. John Moot, representing the Amy Nadel Ten Taxpayer Group, addressed the Council. He noted that he has been working since 1963 in Cambridge to preserve open space, serving on numerous boards and committees. He said the City of Cambridge has appropriated 2 million dollars to buy open space in Cambridge each year and are now allowing the present Neville site, assessed by the city at $6 million for the land alone to be used for an assisted living and adjacent nursing home. Mr. Moot said, "our basic argument is that they are about to take open land and use it for a nursing home that could be placed elsewhere…It does seems to me that that is what this Determination of Need Program is all about – is to prevent the building of additional medical facilities where there isn't an established need." Mr. Moot stated that two other nursing home sites have been turned down as alternative sites for inadequate reasoning (Youville and Cantabridgia). Mr. Moot said, "I question seriously the wisdom of putting a nursing home adjacent to an assisted living facility. It is clear that what you have set up is the assisted living facility as a feeder to the nursing home. Youville is a much better location for a nursing home than up on Fresh Pond. It is right next to the hospital. You can get fine medical care. There is also a rehabilitation center there. The needs for a nursing home for medical care are a lot more important than the need for a nursing home to be able to shift somebody back to assisted living now and then. I would have to say that the staff report on the proposal is all one sided. There was never an effort to balance out our point that Youville was a better location than the Park facility. They just took the word that they got from this applicant. They asked him to comment on our report and they quoted that back to you verbatim. It was as if the staff was part of the applicant's employment." Mr. Moot further questioned the legality of the wage cuts that are planned at the nursing home because it will no longer be part of the City but part of the Health Department.

Mr. William F. Schreiber, Amy Nadel Ten Taxpayer Group, also addressed the Council. He said, "I don't need to remind the Council that the main problem with nursing homes in Massachusetts is solvency. Item 4 on your agenda today is quite relevant to this one because even with the state and the federal government in the best economic condition they have been in decades, there doesn't seem to be the political will to provide adequate money for the kind of health care that people want. For example, emergency rooms in small towns. All the more reason that the Council should be extremely careful not to permit the construction of unnecessary facilities, such as this nursing home. I echo everything Mr. Moot said." Mr. Schreiber further noted that (1) the argument by which this project was approved by the Cambridge City Council and the Legislature are entirely different than the arguments being presented today; and (2) the proponents of Neville Manor submitted letters from relatives and residents of Neville Manor praising the compassionate care they were getting in the existing building. In closing, Mr. Schreiber said, "Buildings do need to be renovated from time to time but it is hard for me to believe that the renovation of either Youville or the existing building would cost more than a new building."

After consideration, upon motion made and duly seconded, it was voted unanimously to approve **Project Application No. 4-1420 of Cambridge Public Health Commission d/b/a Mayor Michael J. Neville Manor Nursing Home, Cambridge**, a summary is attached and made a part of this record as **Exhibit No. 14, 677**, based on staff findings, with a maximum capital expenditure of $9,535,783 (January 2000 dollars) and first year incremental operating costs of $1,048,588 (January 2000 dollars). As approved, the application provides for new construction to replace the existing 179-bed (96 Level II and 83 Level III bed) Neville Manor Nursing Home with a 112 Level II bed facility to be located on the nursing home's existing campus. This Determination of Need is subject to the following Conditions:

1. The applicant shall accept the maximum capital expenditure of $9,535,783 (January 2000 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2. The total approved gross square feet (GSF) for this project is 47,637 GSF for new construction to replace the existing 179-bed (96 Level II and 83 Level III beds) Neville Manor Nursing Home with a 112 Level II bed facility.

3. The applicant shall, prior to construction, sign formal affiliation agreements regarding the new facility with local acute care hospitals and local home care corporations that include a provision for respite services.

4. Upon implementation of the project, any assets such as land, building improvements, or equipment which are either destroyed or no longer used for patient care, shall not be claimed for reimbursement for publicly aided patients.

5. The applicant shall obtain Medicare Certification for its proposed Level II beds.

6. The applicant shall guarantee beds in the new facility for residents residing in the existing facility.

7. The applicant shall ensure that Medicaid transfers from Neville Manor to the new facility will continue to receive care until such time that Medicaid certification is obtained.

8. The Department shall reserve the right to conduct a review of the financial feasibility of the project based on the Division of Health Care Finance and Policy's established rates of reimbursement for Medicaid patients at the time final maximum capital expenditures or any adjustments to the final maximum capital expenditure are submitted to the Determination of Need Program for approval in the event that such

expenditures exceed the approved maximum capital expenditure. The applicant shall submit a revised Factor Five (Financial Schedules) upon request by the Department. The applicant is advised that an increase in equity may be necessary to assure the financial feasibility of the project.

Staff's recommendation was based on the following findings:

1. The applicant is proposing renovation to replace the existing 179-bed (96 Level II and 83 Level III beds) Neville Manor Nursing Home with a 112 Level II bed facility to be located on the nursing home's existing campus.

2. The health planning process for this project is satisfactory.

3. Consistent with the Determination of Need Guidelines for Nursing Facility Replacement and Renovation (Guidelines), the applicant has demonstrated need to replace the existing Neville Manor Nursing Home as discussed under the health care requirements factor of the staff summary.

4. The project, with adherence to certain conditions, meets the operational objectives factor of the Guidelines.

5. The project, with adherence to a certain condition, meets the standard compliance factor of the Guidelines.

6. The recommended maximum capital expenditure of $9,535,783 (January 2000 dollars) is reasonable compared to similar, previously approved projects.

7. The recommended incremental operating costs of $1,048,588 (January 2000 dollars) are reasonable based on similar, previously approved projects. All operating costs are subject to review by the Division of Health Care Finance and Policy and third party payors according to their policies and procedures.

8. The project is financially feasible and within the financial capability of the applicant.

9. The project meets the relative merit requirements of the Guidelines.

10. The Division of Health Care Finance and Policy submitted comments related to the financial feasibility of the project.

11. The project is exempt from the community health initiatives requirement.

12. The Amy Nadel Ten Taxpayer Group registered in connection with the project and requested a public hearing, which was held on February 15, 2000.

The meeting adjourned at 1:10 P.M.

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Howard K. Koh, M.D., M.P.H.
Chairman

LMH

MINUTES OF THE PUBLIC HEALTH COUNCIL

MEETING OF MAY 23, 2000

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH